Spencer Family Dental
147 Spencer Street, Bunbury, WA, 6230
(08) 9721 9591
reception@spencerfamilydental.com.au

PATIENT DETAILS AND MEDICAL HISTORY

PRIVACY STATEMENT: We value your privacy. All of the information which you provide to us will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Statement is attached to this file. Please take the time to read our Privacy Policy before answering the Questionnaire & speak to one of our staff if you have any concerns.

Mr ☐ Mrs ☐ Ms ☐ Master ☐ Miss ☐

First Name _____ Last Name _____

DOB ____/___/_____ Email address _____

Street Address _____

Suburb _____ Post Code ☐☐☐☐

Mobile No. _____ Home Phone _____

Health Fund _____ Occupation _____

Emergency Contact Name _____ Phone No. _____

How did you find out about us? _____ _____

Please Note: We require payment on the day of service. Payment plans must be discussed prior to commencement of treatment.

When was your last visit to the dentist? _____

Briefly outline why you came to the dentist today?

_____

Please provide a brief outline of any previous problems with dental procedures?

_____

How do you feel when visiting the dentist?

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Extremely Nervous	Kinda Nervous	Not so Nervous	Relaxed	Not worried at all

PLEASE TURN OVER TO COMPLETE YOUR MEDICAL HISTORY

Please answer the following medical questions.

How many cigarettes per day	
High sugar frequency	
How many Alcohol drinks per week	
Pregnant or possibly pregnant ☐	
Blood Pressure High ☐ or Low ☐	
Hepatitis A ☐ B ☐ C ☐ or D ☐	
HIV or AIDS	
Haemophiliac	
Other blood conditions	
Diabetes	
Artificial Joint or Joint Replacement	
Cancer ☐ Radiotherapy ☐	
Stroke ☐ Pacemaker ☐	
Depressive Illness ☐	

Please note below any Allergies;

Please note below all current Medications;

Do you suffer from any illness not listed above? _____

Are you suffering from any illness at the moment? _____

Name of your Doctor / Specialist _____

DECLARATION:

In signing this form I acknowledge that this represents an accurate medical history. I will advise my Dentist of any changes to my medical history in the future. I understand that all my medical details will be treated with complete professional confidentiality.

In signing this form I acknowledge that I am responsible for the payment of this account on the day of procedure (unless discussed prior to treatment).

Patient Signature _____ **Date** ____ / ____ / _____